MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address East Harris County 730 North Post Oak Road Houston, Texas 77024	MDR Tracking No.: M4-04-4191-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Lumbermans Mutual Casualty Company Box 39	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: 4600061114

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
12/11/02	**12/11/02**	**99214**	**$71.00**	**$71.00**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's position statement states, "The carrier is denying payment for code 99214 stating pre authorization required but not requested. This charge is for an office visit. Per the 1996 MFG and per rule 134.600 this code is payable and does not require pre authorization. We believe we have complied by all the rules set forth by the commission and should be paid for services rendered."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response states, "There is no documentation received to substantiate why Dr. S is requesting an office visit if the claimant was in the hospital. The billing also has both diagnosis codes for the back and the knee. Provider states that the bill was only for the knee and not the back. If that is the case then the bill should only have the diagnosis for the knee since the carrier cannot separate the charges." Carrier's EOB denial is "F=Fee guideline MAR reduction. A-Preauthorization required but not requested/treatment was not pre-authorized (TX only) audit only."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per rule 134.600 preauthorization is not required for an office visit. Documentation supports the level of office visit billed per MFG E/M (IV)(C).

Therefore, reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

				Total Left Column:			$0.00
				Total Amount Due:			$71.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled reimbursement in the amount of **$71.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.

Ordered by:

	Michael Bucklin	12/27/04
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____